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NO. _____

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**IN THE SUPREME COURT OF THE UNITED STATES**
OCTOBER TERM, 1985

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JOSEPH ALTON BOWERS

Petitioner

versus

THE CONTINENTAL INSURANCE COMPANY

Respondent

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**PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT**

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## STATEMENT OF QUESTIONS PRESENTED

(1) Whether 28 U.S.C. §1332(c) allows a no-fault insurance lawsuit to be removed from a state court having proper jurisdiction and venue to the United States District Court, or whether such a case falls within the class of cases covered by the "direct action" proviso adopted by Congress in 28 U.S.C. §1332(c) to prevent an over abundance of insurance lawsuits of a local nature from being litigated in the federal court system.

(2) Whether the "stacking" of optional no-fault insurance benefits, that is the pyramiding of coverages from

different policies, is precluded by the Georgia Motor Vehicle Accident Reparations Act, O.C.G.A. Chap. 33-34.

(3) Whether a federal court may as a matter of law deny statutory penalties imposed by O.C.G.A. §33-34-6 for late payment of no-fault insurance benefits when it is undisputed that the insurance company owed the benefits, did not pay the benefits within the time permitted by the statute, and introduced no evidence to explain its conduct.

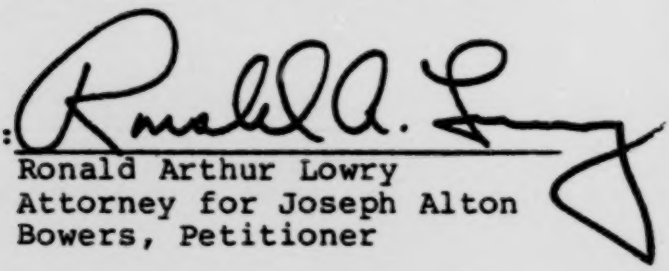
## INTERESTED PARTIES

The undersigned counsel of record certifies that the following listed persons are parties to the proceedings in the Court whose judgment is sought to be reviewed:

Joseph Alton Bowers, Petitioner

The Continental Insurance Company, Respondent

ZUSMANN, SMALL, STAMPS & WHITE
A Professional Corporation

By: 

Ronald Arthur Lowry
Attorney for Joseph Alton Bowers, Petitioner

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## GROUNDS FOR WHICH SUPREME COURT JURISDICTION IS SOUGHT TO BE INVOKED

Petitioner seeks the Writ of Certiorari because the decision of the United States Court of Appeals for the Eleventh Circuit in the instant case rendered on February 27, 1985 (rehearing denied March 28, 1985) is in conflict with the decision of the United States Circuit Court of Appeals for the Sixth Circuit in the case of Ford Motor Co. v. Insurance Co. of North America, 669 F.2d 421 (6th Cir. 1982) on the jurisdictional question presented. Further, the decision in the instant case rewrites 28 U.S.C. §1332(c) by ignoring the plain language of that statute and has so far departed from the accepted and usual

course of judicial proceedings as to call for an exercise of this Court's power of supervision. The opinion in the instant case also rewrites O.C.G.A. Chapter 33-34 regarding the amount of no-fault insurance benefits to be awarded and the penalties upon an insurer for failure to pay no-fault insurance benefits in a timely manner. The jurisdiction of this Honorable Court is invoked under 28 U.S.C. §1254(1).

## STATEMENT OF THE CASE

On August 24, 1981, Plaintiff-Petitioner, Joseph Alton Bowers, was involved in a one car motor vehicle accident on Brumelow Road in North Fulton County, Georgia (R-245). As a result of that motor vehicle accident, Petitioner suffered devastating injuries including partial paralysis with some brain and spinal cord damage. Petitioner has not worked since the date of the accident and is permanently disabled from future employment (R-247). Petitioner's total medical expenses are now $103,198.14 (R-247).

Petitioner made a no-fault insurance claim against Aetna Insurance Company,

the insurer of the motor vehicle in which Petitioner was riding, for medical bills and lost wages incurred by him up to that time and received a total of $43,750.00[1] (R-247, R-189). By letter dated April 26, 1982, Petitioner made a no-fault insurance claim against Respondent, Continental Insurance Company, for those remaining benefits due to Petitioner based upon two policies of insurance issued by Continental Insurance Company to Petitioner on his personal

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[1] Under Georgia law the insurance policy insuring the automobile in which the injured person is riding has primary coverage. Policies on other vehicles under which the injured person is a named insured are treated as excess, or secondary, coverage. Petitioner received $5,000.00 in basic no-fault benefits plus $38,750.00 in optional no-fault benefits from Aetna by virtue of a compromise without filing suit.

vehicles (R-246). No response was made by Respondent to this letter (R-246).

Simultaneously with the April 26, 1982 letter, Petitioner sent Respondent copies of medical bills totalling in excess of $92,000.00, the amount of medical expenses known at that time. Suit was filed by Petitioner on July 27, 1982 pursuant to O.C.G.A. Chapter 33-34. On May 31, 1983, Respondent sent Petitioner a check in the amount of $6,250.00, attached to a Release and Dismissal of the case. On June 3, 1983, Petitioner returned the check, Release and Dismissal to Respondent. On October 20, 1983, after the trial court's ruling, Respondent tendered a check (which Petitioner accepted) in the amount of

$6,250.00 without attaching a Release or Dismissal as a condition of acceptance. The parties agreed that the acceptance of this amount would not preclude Plaintiff from going forward with Plaintiff's claims for additional amounts.

## STATEMENT OF THE COURSE OF PROCEEDINGS AND DISPOSITION OF THE CASE BELOW

Petitioner filed suit against Respondent in the State Court of DeKalb County, Georgia (R-6). Respondent removed this case to the United States District Court for the Northern District of Georgia (R-4). Petitioner sought to have the case remanded to the State Court

of DeKalb County, Georgia (R-31, R-40) but Petitioner's Motion for Remand was denied by the trial court by an Order dated September 27, 1982 (R-66). Petitioner sought to obtain certification for an interlocutory appeal, however such certification was denied by the trial court by Order dated December 22, 1982 (R-90).

Respondent, Continental Insurance Company, answered Plaintiff's Complaint denying it owed Petitioner anything whatsoever and also filed a counterclaim for declaratory relief (R-17). After discovery, Petitioner filed his Motion for Summary Judgment or Alternatively for Partial Summary Judgment seeking his no-fault benefits from Respondent (R-179).

Respondent filed a Cross Motion for Declaratory Relief (R-199). Petitioner responded with a Brief in Opposition (R-228).

By Order dated October 4, 1983, the trial court denied Petitioner's Motion and granted Respondent's Motion, however the trial court in that Order also awarded Petitioner the sum of $6,250.00 (R-259). In that same Order, the trial court reserved the issue of Petitioner's attorney's fees, statutory penalties and punitive damages for a later determination (R-259). Petitioner filed a Notice of Appeal from that Order (R-272).

Subsequently, the trial court granted Respondent's Motion to Strike Petitioner's Request for Attorney's Fees,

Statutory Penalties and Punitive Damages, by Order dated January 13, 1984 (R-290). Petitioner filed a second Notice of Appeal from the judgment of January 13, 1984 (R-298). The two appeals were consolidated. On February 27, 1985, the panel of the United States Court of Appeals for the Eleventh Circuit affirmed the decision of the trial court in this matter. On March 28, 1985, the United States Court of Appeals for the Eleventh Circuit denied Petitioner's Petition For Rehearing And Suggestion For Rehearing En Banc.

## SUMMARY OF ARGUMENT

JURISDICTION. Petitioner originally filed suit against Respondent in a state court. Respondent removed the case to the United States District Court for the Northern District of Georgia. Petitioner sought to have the case remanded to the state court, which Motion for Remand was denied. Petitioner contends that under 28 U.S.C. §1332(c) the case should have been remanded because the federal court has no jurisdiction to hear this controversy. Specifically, the instant case falls within that class of cases covered by the "direct action" proviso adopted by Congress to prevent an over abundance of

insurance lawsuits of a local nature from being filed in federal court.

STACKING QUESTION. The central issue of this appeal involves "stacking" optional benefits under no-fault coverages afforded by the Georgia Motor Vehicle Accident Reparations Act. Petitioner has medical expenses and lost wages in excess of all available coverages. Petitioner is attempting to mount insurance coverages on top of each other to the total limits of all policies. Respondent contends that Petitioner can only recover up to the limit authorized by law to be written for one policy. Petitioner argues that the Georgia statutory no-fault scheme allows this "stacking."

ATTORNEYS FEES, STATUTORY PENALTIES AND PUNITIVE DAMAGES. Attorney's fees, statutory penalties and punitive damages are authorized under the Georgia Motor Vehicle Accident Reparations Act if an insurer does not make payment of benefits on time. In this case, the insurer admitted at the time of filing of the trial court briefs that it owed Petitioner $6,250.00. Respondent later paid that figure to Petitioner under a stipulation that acceptance by Petitioner would not affect any of Petitioner's rights in this litigation. However, this payment was made more than one and one-half years after the initial demand by Petitioner and more than five months from the date Petitioner answered interrogatories giv-

ing financial information to Respondent from which exact calculations regarding the amount Respondent owed Petitioner could be ascertained, even if Respondent had not obtained this information previously.

The Georgia Motor Vehicle Accident Reparations Act requires that the insurer make payment within thirty days or be subjected to statutory penalties and attorney's fees, and if payment is made after sixty days, the insurer is subjected to punitive damages with the burden of proof upon the insurer that any delay came about in "good faith." No evidence has been introduced by the insurer regarding a reason for the delay. The Eleventh Circuit ruled that the insurer

acted in good faith as a matter of law. Petitioner contends that, at the very minimum, there exists a question of fact to be resolved by the trier of fact as to this issue.

## ARGUMENT AND CITATION OF AUTHORITY

### JURISDICTIONAL QUESTION

It is a general legal principle that statutes are to be strictly construed. This principle has been reaffirmed recently by this Court. See Tennessee Valley Authority v. Hill, 437 U.S. 153, 98 S. Ct. 2279, 57 L. Ed.2d 117 (1978); Griffin v. Oceanic Contractors, Inc., 458 U.S. 564, 102 S. Ct. 3245, 73 L. Ed.2d 973 (1982); Consumer Product Safety

Commission v. GTE Sylvania, Inc., 447 U.S. 102, 100 S. Ct. 2051, 64 L. Ed.2d 766 (1980).

The initial issue for determination by this Court concerns the question of jurisdiction of the federal courts to hear the controversary presented by this case. Respondent, Continental Insurance Company, is a New York insurance carrier doing business in the State of Georgia and is properly subject to the jurisdiction and venue of the State Court of DeKalb County. Petitioner Bowers is a resident of DeKalb County, Georgia. No contention has been made by Respondent that it is not subject to the jurisdiction of the State Court of DeKalb County, but rather the removal petition sought to

have the subject litigation removed to the United States District Court pursuant to the provisions of 28 U.S.C. §1332 and §1441.

The above cited code sections authorize a defendant in a state court action to remove a case in which diversity of citizenship exists to the United States District Court. After establishing the class of cases having federal jurisdiction via diversity, 28 U.S.C. §1332 goes on to limit federal jurisdiction for certain cases involving insurance companies by the inclusion of the following proviso:

> Provided further, That in any direct action against the insurer of a policy or contract of liability insurance, whether incorporated or unincorporated, to which action the insured is

> not joined as a party-defendant, such insurer shall be deemed a citizen of the State of which the insured is a citizen, as well as of any State by which the insurer has been incorporated and of the State where it has its principal place of business. 28 U.S.C. §1332(c). (Emphasis theirs).

In the case at bar, Petitioner has filed a "direct action against the insurer of a policy or contract of liability insurance" and "to which action the insured is not joined as a party Defendant" as contemplated by the provisions of the statutory authority stated above, and as a result the case is not proper to be removed to the federal court system because no diversity exists under §1332(c).

The question of the removal of no-fault insurance cases filed in the state courts has been addressed previously. In an action similar to the case at bar, the United States District Court for the Eastern District of Michigan held as follows:

> There are a number of reasons why although not specifically passed to eliminate diversity in no-fault cases the proviso should apply to diversity so created. First, there can be no question that no-fault is still a part of an on going tort liability system. (Cites omitted). No-fault actions possess the hallmarks of direct actions. McMurry v. Prudential Property and Casualty Insurance Co., 458 F. Supp. 209 at p. 211 (E.D. Mich. 1978).

After first determining that it is appropriate to apply the language of the

proviso to a no-fault insurance lawsuit, the court in McMurry went on to conclude as follows:

> It is also apparent that the no-fault statute in Michigan is a species of direct action. The Michigan No-fault Insurance Act (cites omitted) represents a state reform that makes it possible to bring suit in certain cases directly against an insurer, rather than suing the tortfeasor in a common lawsuit. Federal courts hearing analogous worker's compensation cases have been satisfied that worker's compensation suits can be direct actions within the meaning of the proviso, that is, the case is immediate between the injured claimant and the insurer (cites omitted). Both no-fault and worker's compensation cases are similar to the original direct action statutes in that they both allow suit to be brought directly against an insurer as a result of state legislative action. McMurry, at p. 212.

The reasoning contained in McMurry has been adopted by the United States Court of Appeals for the Sixth Circuit in the case of Ford Motor Co. v. Insurance Company of North America, 669 F.2d 421 (11th Cir. 1982). In that case, the Court raised the jurisdictional question on its own motion at oral argument. Both sides urged the Court to uphold jurisdiction however the Court determined that no jurisdiction existed in the federal courts for this type of controversy.

> We conclude that the decisions in McMurry and Tyson contain the correct view of the applicability of the 1964 amendment to actions under the Michigan no-fault act. The impetus for the amendment was the situation which resulted when Louisiana and Wisconsin departed from the traditional practice of treating the

insured rather than the insurer as the real party in interest in automobile negligence cases. However, if its language encompasses other situations, we should not limit application of the amendment to the specific conditions which gave it birth. The language of the amendment is inclusive rather than exclusive: 'in any direct action against the insurer of a policy or contract of liability insurance . . . to which the insured is not joined as a party defendant . . . .' (Emphasis added). As has been noted earlier, MCLA §500.3135(2) abolished tort liability arising from the ownership, maintenance or use of a motor vehicle in Michigan. As a substitute for such tort liability, Michigan provided 'personal protection benefits' and 'property protection benefits' for those injured or suffering property damage arising out of the ownership, maintenance or use of such vehicles. These benefits are provided on a no-fault basis rather than on the basis of traditional tort liability, and actions to

> secure the benefits may be maintained directly against the insurer of the vehicle rather than the insured. The literal requirements for the application of the proviso are met. Ford Motor Co. v. Insurance Company of North America, 669 F.2d 421 at p. 425 (6th Cir. 1982).

In going further and explaining the reason for this ruling, the Ford court stated as follows:

> Unless the proviso is held to apply, the same 'back door diversity' which Congress eliminated by the 1964 amendment would be possible under no-fault. No-fault represents a latter-day attempt by the states to improve the mechanism for recovery by those injured and damaged in accidents arising out of the use of motor vehicles. Given Congress' reaction to earlier state legislation which permitted direct actions, no-fault should not be held to expand the jurisdiction of

federal courts. Ford, at pp. 425, 426 (1982).

At page 2247 (Appendix "A" pp. A-11, A-12) of the opinion in this case, the decision placed great weight upon the concept that the direct action proviso was passed to remedy the problem created by the passage of direct action statutes by the legislatures of Louisiana and Wisconsin:

> The proviso was passed in response to statutes authorizing actions against the holder of a contract of indemnity for liability by a wrongdoer to the plaintiff. See S. Rep. No. 1308, 88th Cong. 2d Sess. reprinted in [1964] U.S. Code Cong. & Ad News 2778, 278-279 . . .

The decision's reasoning is flawed. The question of limiting the direct action proviso to the classic situation presented by the Louisiana/Wisconsin

direct action statutes has been addressed previously by the United States Court of Appeals for the Fifth Circuit in Hernandez v. Travelers Insurance Co., 489 F.2d 721, 723 (5th Cir. 1974) and rejected:

> Reviewing this history, the appellee argues that Congress intended that the amendment should apply only to direct actions brought under statutes similar to the Wisconsin and Louisiana statutes - that is, statutes providing for direct actions in motor vehicle or in tort cases.
>
> We cannot accept this argument. Whatever may have been the specific evil prompting congressional action in 1964 Congress chose to remove all direct actions from the diversity jurisdiction. The language of the statute is not subject to a limitation to motor vehicle cases, or to cases where the insured's

liability is imposed by tort law. (Emphasis theirs.)

The case law previously decided by the United States Court of Appeals for the Fifth Circuit prior to the formation of the Eleventh Circuit has been adopted by the Eleventh Circuit. Bonner v. City of Prichard, Alabama, 661 F.2d 1206 (11th Cir. 1981).

The only reason for failing to give full meaning to a literal interpretation of a statute is that it would produce an absurd and unjust result which Congress could not have intended and which "would thwart the obvious purpose of of the statute." Griffin v. Oceanic Contractors, Inc., 102 S. Ct. 3245, 3250 (1982). However, such is not the situa-

tion presented by the case at bar. The stated purpose of the direct action proviso of 28 U.S.C. §1332(c) is to limit the jurisdiction of the federal courts to hear this very type of insurance dispute. In reaching its decision in Ford (a decision exactly opposite to the decision of the Eleventh Circuit in the instant case), the Sixth Circuit makes the following cogent observation:

> No-fault insurance had not been adopted in any jurisdiction when Congress enacted the 1964 amendment to §1332(c). However, in one respect, no-fault insurance operates in exactly the same way as the Louisiana and Wisconsin direct action statutes - it permits a person claiming injury or damage arising from the ownership or use of a motor vehicle to sue the insurer rather than the

owner or operator of the vehicle. Ford, at p. 425.

The Eleventh Circuit opinion in this case distinguishes Ford on the basis that, unlike Ford, the instant case involves a suit brought by an insured against his own insurer. However, this ignores the plain language of the statute. It is not the status of the insured as plaintiff which is dispositive of the issue raised by §1332(c). It is the status of the defendant as an insurer and the residence of the named insured under the policy of liability insurance which control.

The decision of the Eleventh Circuit in the instant case would produce absurd results. Under Georgia law, a pedestrian

injured in an automobile accident is covered by the liability insurance policy containing no-fault benefits applicable to the automobile which strikes him. Drawing the line where the decision in the instant case has drawn it (i.e., status of the "insured" as plaintiff in the case being dispositive), an injured driver suing the insurance company for no-fault benefits does present a case having federal jurisdiction via diversity, while an injured pedestrian suing the insurance company for no-fault benefits does not. Petitioner respectfully submits that this is not the proper manner in which to determine federal jurisdiction in no-fault insurance cases.

Nor is the argument that a no-fault insurance claim is not a "tort" claim in the classic sense dispositive of this issue either:

> Congress, when it used the terms 'direct action' and 'liability insurance' in the amendment to §1332(c), did not intend the amendment to apply only to traditional tort claims. Aetna Casualty & Surety Insurance Co. v. Greene, 606 F.2d 123, 126 (6th Cir. 1979).

Two of the three states encompassing the Eleventh Circuit have adopted the no-fault insurance system for automobile accident cases, specifically Florida and Georgia. Florida recently increased the minimum limits for no-fault insurance to $10,000.00. Georgia has had optional no-fault limits of $10,000.00 and above since 1975. The possibility now exists, under the Eleventh Circuit opinion in

in this case, for a flood of no-fault insurance disputes in Florida and Georgia to be litigated in the federal court system. As observed by the United States District Court for the Eastern District of Michigan:

> It is obvious that Michigan's no-fault act is the sort of legislation Congress intended to cover in the proviso. But for the change created by the Michigan State Legislature, there would be no apparent jurisdiction in federal court to hear accident cases of an essentially local nature. It cannot be argued that the Michigan legislature intended to have or even could have any effect on federal jurisdiction by reforming its tort laws. In particular, where there are larger federal interests at stake - in this case, reducing the overload on federal dockets - it is encumbent upon a federal court to apply the law to further the congressional policy. (Cites

> omitted). As an independent system, the federal courts must be concerned with the effect of a state law which disrupts the federal system (cites omitted) and places an undue burden on it. McMurry, at pp. 212, 213.

Petitioner respectfully suggests that certiorari should be granted on this jurisdictional question. In a concurring opinion at page 2249 (Appendix "A" p. A-21), one of the judges on the panel deciding this case shows some discomfort with the holding of the Court on this jurisdictional question:

> The instant case made me uneasy because it was not made plain at first why 'direct action' did not mean any and every 'direct action' in which the insurer was duly named as a defendant. This court says this would appear to be the result 'at first glance.' The reported cases seem to pass over rather lightly why this is not so on second and subsequent

> glances. I think perhaps they took it for granted and were not yet warned by the Supreme Court not to rewrite or vary statutory language whenever it seemed good to them to do so.

The decision in the case at bar rewrites 28 U.S.C. §1332(c) and should be reversed.

## STACKING QUESTION

The central issue presented by this appeal is the question of "stacking" of additional (also called "optional") PIP (also called "no-fault") coverages, that is, mounting the coverages afforded by one policy on top of coverages afforded by another policy.

In 1974 the General Assembly of Georgia enacted the Georgia Motor Vehicle Accident Reparations Act which is codified at O.C.G.A. Chapter 33-34. In enacting this legislation, the General Assembly changed the scheme for the compensation of injuries sustained in automobile accidents in the State of Georgia. Under this new "no-fault" plan, all persons operating motor vehicles in the State of Georgia were required to maintain insurance on their automobiles or trucks, and all insurance companies were required to write no-fault coverage for

each motor vehicle liability policy with a minimum no-fault coverage limit of $5,000.00 per injured person per accident. Under O.C.G.A. §33-34-5, persons were given the right of purchasing additional coverage on an optional basis with the highest amount of optional coverage to be written on a single policy being $50,000.00. In the instant case, it is undisputed that Petitioner is an insured under three policies applicable to this accident. The first policy, written by Aetna Insurance Company, insured the truck in which Petitioner was riding. Under Georgia law, the policy

insuring that motor vehicle is primary. The Aetna policy paid Petitioner $43,750.00.[2] Petitioner also had two separate policies with Respondent, Continental Insurance Company, on two individual automobiles which he owned. By operation of law, each Continental policy provides $5,000.00 in minimum limit no-fault protection and $45,000.00 in optional limit no-fault protection. It is undisputed that Petitioner has medical bills and lost wages in excess of all coverages afforded by all policies. Thus the total amount of the optional

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[2] This amount is as a result of a compromise with Aetna. The amount of the Aetna policy including minimum coverage and optional no-fault coverages offered by operation of law was $50,000.00.

coverages afforded by Petitioner's insurance policies with Respondent should be recovered by Petitioner in this case.[3] The Aetna policy discussed previously provides coverages to Petitioner by reason of his physically being inside the motor vehicle at the time of the accident. The two policies issued by Respondent, Continental Insurance

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[3] Petitioner originally filed suit for $42,419.16 plus $10,604.79 as statutory penalties, plus punitive damages and attorney's fees. On October 21, 1983, after all special damages were ascertained, Petitioner amended his Complaint to seek $90,000.00 in insurance benefits, $22,500.00 as statutory penalties, plus punitive damages and attorney's fees.

Company, provide coverage to Petitioner by virtue of his being a "named insured" under the two policies.[4]

The resolution of this stacking question calls for the construction of four sections of the Georgia Motor Vehicle Accident Reparations Act, specifically, O.C.G.A. §33-34-4(a)(2), O.C.G.A. §33-34-4(c), O.C.G.A. §33-34-2(5) and O.C.G.A. §33-34-5. (See Appendix "C").

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[4] Under Georgia law, "stacking" of optional no-fault coverages from one policy above coverages from another policy has long been allowed. See Georgia Farm Bureau Mutual Insurance Co. v. Musgrove, 153 Ga. App. 690, 266 S.E.2d 228 at p. 229 (1980). The question before this Court deals with Respondent's contention that a "cap" exists whereby Petitioner is not entitled to recover optional no-fault insurance benefits above the highest amount authorized by the no-fault statute to be written under a single policy.

The "stacking" issue of this appeal has been addressed by the Supreme Court of South Carolina in the case of Belk v. Nationwide, 244 S.E.2d 744 (S.C. 1978), a case similar to the case at bar but decided under South Carolina law. The plaintiff, Belk, was injured in an automobile accident and was insured by two policies both written by Nationwide. Each policy, pursuant to South Carolina law, provided basic personal injury protection benefits (PIP) in the amount of $1,000.00 and additional personal injury protection benefits (APIP) in the amount of $4,000.00 for a total coverage of $5,000.00 under each policy. Belk filed suit claiming he was entitled to $10,000.00 by virtue of "stacking" both

policies as his medical bills and lost wages exceeded $10,000.00.

Nationwide argued that it was only obligated to pay a maximum of $5,000.00 under the first policy and had no liability under the second policy. Nationwide's argument was that a section of the South Carolina law prevented plaintiff's recovery of benefits for more than one policy, and Nationwide had a clause in its policies excluding such additional coverage. The section of the South Carolina No-fault law in question, §56-11-110 of The 1976 Code of South Carolina, is similar to the Georgia no-fault section, §33-34-4(c) cited previously herein.

> "Notwithstanding any other provision of this chapter, no person shall recover benefits under the coverages required in §56-11-110 from more than one such policy of liability insurance or insurer on either a duplicate or supplemental basis." §56-11-110 of The 1976 Code of South Carolina.

The plaintiff countered with the argument that the statute cited by Nationwide would, at most, prohibit recovery of basic PIP a second time and that the APIP (also known as "optional" PIP) in the amount of $4,000.00 would still be payable.

The lower court awarded plaintiff the entire amount of the second policy. The Supreme Court of South Carolina ruled:

> "We hold that the lower court erred in concluding that

> Belk could recover the basic $1,000.00 PIP benefits under the second policy, but we affirm its award of the $4,000.00 APIP benefits under the second policy." Belk, at p. 746.

The rationale behind the South Carolina Supreme Court's decision was that §56-11-110 of The 1976 Code of South Carolina cited by Nationwide only prevented stacking of two basic PIP coverages but did not prevent stacking of the additional PIP, thus any exclusion in the policy which purported to prevent stacking of the additional PIP was void. Belk serves to illustrate the distinction between basic PIP and additional or optional PIP. In the case now before this Court, O.C.G.A. Chapter 33-34 and the policy language of the Continental

policies only prevent stacking of basic PIP benefits. The result should be the same in the instant case as in Belk, specifically Petitioner should be allowed to recover the additional PIP from both policies, but not basic PIP.

As Petitioner has previously received the minimum no-fault limits of $5,000.00 as part of Aetna's payment to him, the minimum no-fault limits of $5,000.00 under the two Continental policies cannot be recovered. However, the additional optional benefits under those two policies in the amount of $45,000.00 each would be recoverable with the total limit for both policies being $90,000.00. Since Respondent has conceded it owed Petitioner a portion of the

amount claimed and has paid Petitioner $6,250.00, Respondent now owes Petitioner $83,750.00.

Georgia law requires that Petitioner be entitled to stack coverages in this case. It is Petitioner's position that the various sections of the Georgia Motor Vehicle Accident Reparations Act are to be construed together. In examining these Code Sections, it is apparent that they fit together to form a comprehensive package of benefits. Specifically, O.C.G.A. §33-34-4(a)(2) provides for the minimum coverages to be afforded under the Georgia no-fault law. O.C.G.A. §33-34-5(a) provides for optional PIP up to an additional $45,000.00 for a total under any one policy of $50,000.00.

O.C.G.A. §33-34-2(5) limits the minimum PIP coverage available to an injured person by defining the term "insured" to include a person injured by an automobile "when such motor vehicle is not similarly insured as required" by O.C.G.A. §33-34-4(a)(2), thus making such a person not an "insured" under any other policies. O.C.G.A. §33-34-4(a)(2) refers only to minimum PIP limits. Additional, or optional, PIP is provided for under O.C.G.A. §33-34-5(a). The limiting language only prevents stacking of minimum limit no-fault insurance of $5,000.00.

Thus, under the definition of the word "insured" found in the Georgia no-fault law, the injured party has coverage for the minimum limits under his personal

policy only when the automobile from which he ordinarily would receive no-fault coverage is not insured for the minimum limits. No such restriction appears with regard to optional limits under O.C.G.A. §33-34-5(a). Statutes are to be strictly construed. Since O.C.G.A. §33-34-2(5) itself does not preclude one from being an "insured" for the optional limits as it does for the minimum limits then stacking of optional limits ought to be allowed. If the legislature had wanted to prevent stacking of the optional benefits the legislature would have also included a reference to the optional limits section of the no-fault law in the limiting language of O.C.G.A. §33-34-2(5)

thereby removing a person attempting to stack optional no-fault from the definition of "insured."

In reaching its conclusion in Belk, the Supreme Court of South Carolina employed a similar analysis:

> Section 56-11-150 refers only to the coverage required in §56-11-110, i.e., the basic $1,000.00 PIP coverage. The limiting statute makes no reference to APIP benefits which are required to be made available by §56-11-120, and in the absence of legislative intention indicating otherwise, we refuse to hold that the legislature intended to prevent an insured from recovering APIP benefits under more than one policy. Belk, at p. 746.

The Supreme Court of Georgia, Georgia's highest court, has not yet ruled on the stacking question presented by Petitioner in this case. One panel of

an intermediate appellate court, the Georgia Court of Appeals, has addressed this issue adversely to the position of Petitioner in Voyager Casual y Insurance Co. v. King, 172 Ga. App. 269, 323 S.E.2d 4 (1984). However, the Voyager decision does not address the proper construction of these statutes in combination but rather fixes on the language of O.C.G.A. §33-34-4(c) alone. The Voyager court misreads O.C.G.A. §33-34-4(c) because of its failure to take into consideration the other statutes.

O.C.G.A. §33-34-4(c) is subject to two meanings. Specifically, that statute can be read to mean:

(1) That the recovery of no-fault "shall not exceed the sum of .

$5,000.00 . . . or such greater amount of coverages has been purchased on an optional basis" under any one policy "regardless of the number of insurers providing such benefits or of the number of policies providing such coverages;" or

(2) That the recovery of no-fault "shall not exceed the sum of $5,000.00 . . . regardless of the number of insurers providing such benefits or of the number of policies providing such coverage" but an injured person can recover "such greater amount of coverage as has been purchased on an optional basis . . . regardless of the number of insurers providing such benefits or the

number of policies providing such coverage."

Petitioner respectfully submits that Voyager was simply decided incorrectly. In order to determine which of the two interpretations of O.C.G.A. §33-34-4(c) is correct the other statutes must be considered as well. The highest Court in Georgia, the Supreme Court of Georgia, has never addressed this issue. The Supreme Court of Georgia has reversed the Court of Appeals repeatedly on questions involving construction of the Georgia Motor Vehicle Accident Reparations Act. See Flewellen v. Atlanta Casualty Co., 250 Ga. 709, 300 S.E.2d 673 (1983); St. Paul Fire & Marine Insurance Co. v. Nixon, 252 Ga. 469, 314 S.E.2d 215

(1984); Wiard v. Phoenix Insurance Co., 251 Ga. 698, 310 S.E.2d 221 (1983); Enfinger v. International Indemnity Co., 253 Ga. 185, 317 S.E.2d 816 (1984); Government Employees Insurance Co. v. Mooney, 250 Ga. 760, 300 S.E.2d 799 (1983); Tolison v. Georgia Farm Bureau Mutual Insurance Co., 253 Ga. 97, 317 S.E.2d 185 (1984); Colwell v. Voyager Casualty Insurance Co., 251 Ga. 744, 309 S.E.2d 617 (1983).

Recently, the Eleventh Circuit certified a question to the Supreme Court of Georgia concerning the construction of the Georgia no-fault statute on a point different from that presented by the instant case. See United States v. Travelers Indemnity Co., 253 Ga. 328, 320

S.E.2d 164 (1984). However, in the case at bar the Eleventh Circuit chose not to send a certified question to the Supreme Court of Georgia concerning this issue despite Petitioner's Motion that such a certified question be presented.

The decision by the Eleventh Circuit Court of Appeals in the instant case on the issue of stacking of optional no-fault benefits is wrong for two reasons:

(1) The decision of the Eleventh Circuit Court of Appeals does not analyze the statutory framework necessary to reach the correct decision as would the highest court of the State of Georgia, but rather merely adopts the decision of an intermediate appellate court which, as

has been pointed out previously in this Brief, was decided incorrectly.

(2) The decision by the Eleventh Circuit Court of Appeals in the instant case is morally wrong. The net effect of this decision is that all persons in the State of Georgia who have more than one insurance policy under which they are named insureds for purposes of optional no-fault benefits have received nothing in return for premiums paid for optional no-fault under one of the policies. For example, if a person owns two automobiles and has purchased minimum and optional no-fault benefits for the first automobile totalling $50,000.00, and minimum and optional no-fault benefits for the second automobile totalling $50,000.00,

and that person receives a serious injury in an automobile accident resulting in medical bills in excess of $100,000.00, under the decision of the Eleventh Circuit Court of Appeals in the instant case that person will not receive one cent in no-fault benefits from the second policy. In short, the insured has paid a premium and received nothing in return.

Petitioner respectfully urges this Court to grant certiorari and reverse the decision of the Eleventh Circuit Court of Appeals on this issue.

## STATUTORY PENALTIES

The Eleventh Circuit is mistaken in finding as a matter of law that Petitioner was not entitled to attorney's fees, statutory penalties or punitive damages. O.C.G.A. §33-34-6 provides that an insurer must make payment within thirty days of the claim to avoid penalties and attorney's fees and within sixty days to avoid punitive damages. (See Appendix "C").

The test under the Georgia no-fault statute is one of good faith of the insurer. The burden of proving such good faith is on the insurer. The fact that an issue may be one of first impression

does not insulate an insurance company from liability for bad faith for failure to timely pay a claim. Bitumuous Casualty Corp. v. Mowery, 145 Ga. App. 45, 244 S.E.2d 573 (1978).

The Eleventh Circuit opinion cites cases which placed the burden of proving bad faith on the plaintiff, rather than on the insurance company defendant as does the no-fault statute. The cases cited also do not support the conclusion reached in the opinion.

In the instant case, it is undisputed that Petitioner sent Respondent a demand on April 26, 1982 and that suit was filed on July 27, 1982, a period in excess of ninety days. It is during this period that the insurer should have

investigated to determine the validity of the claim. Instead, Respondent chose to do nothing and has introduced no evidence whatsoever that it conducted any investigation into the validity of this claim during that period.

> It has also long been established as the rule that the complete failure of the insurer to prove any defense to an action on the policy is evidence of the bad faith contemplated by Code §56-706, and subjects the insurer to a verdict for the statutory penalty and attorney's fees. (Cites omitted). This is especially true where the insurer does not prove that reasonable investigation of the insured's claim was made within the sixty day period after demand for payment, in terms of the statute, has been made. Reserve Life Insurance Co. v. Ayers, 217 Ga. 206 at p. 213, 121 S.E.2d 649 at p. 654 (1961).

At page 2248 of the decision (Appendix "A" p. A-19), the Eleventh Circuit makes the following incorrect factual observation:

> "It is undisputed that during this time Continental reasonably believed that Aetna had paid Bowers $50,000.00 rather than $43,750.00."

Literally pages and pages of argument have been submitted by Petitioner as to the lack of reasonableness on the part of Respondent after receipt of Petitioner's April 26, 1982 demand letter. Respondent did not even contact Petitioner's counsel or conduct an investigation about the claim. Respondent totally ignored the demand letter, never sending a reply. Even after Petitioner did Respondent's work for it, by providing in

Answers To Interrogatories a complete breakdown of the amounts paid to Petitioner by Aetna, Respondent still waited until after the trial court's ruling, a period of more than five months, before unconditionally paying Petitioner benefits which Respondent admits it owed all along.

Petitioner respectfully submits that, at the very least, a question of fact is present as to whether or not the insurer acted in good faith.

## CONCLUSION

The decision of the United States Court of Appeals for the Eleventh Circuit in this case is of extreme significance

to the Eleventh Circuit and the nation. The jurisdictional question is one of first impression in the Eleventh Circuit, and the decision in this case is directly at odds with an earlier decision of the United States Court of Appeals for the Sixth Circuit concerning this identical issue. By rewriting 28 U.S.C. §1332(c), the Eleventh Circuit decision opens the door for the introduction of literally thousands of insurance lawsuits of essentially a local nature into the federal court system.

The decision in the instant case deprives thousands of persons of no-fault insurance protection for which those persons have already paid millions of dollars in premiums. The decision places

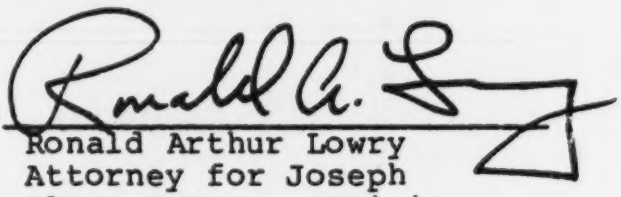
an arbitrary maximum of $50,000.00 upon no-fault insurance recoveries in Georgia no matter how much optional no-fault insurance coverage has been purchased by the insured.

The Eleventh Circuit decision also rewrites a Georgia statute, O.C.G.A. §33-34-6, to do away with the burden of proof on the insurer to establish that it had acted in good faith. Without any evidence in the record concerning the Respondent insurance company's activities, the opinion in this case presupposes good faith on the part of Respondent.

Petitioner, Joseph Alton Bowers, respectfully requests that this Court

grant certiorari on this matter and further requests that this Court reverse the decision of the United States Court of Appeals for the Eleventh Circuit.

ZUSMANN, SMALL, STAMPS & WHITE
A Professional Corporation

By: 
Ronald Arthur Lowry
Attorney for Joseph
Alton Bowers, Petitioner

# APPENDICES

**APPENDIX "A"**

**JOSEPH ALTON BOWERS**

Plaintiff-Appellant

v.

**CONTINENTAL INSURANCE COMPANY**

Defendant-Appellee

United States Court of Appeals,
Eleventh Circuit

February 27, 1985

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Appeals from the United States District Court for the Northern District of Georgia.

Before HENDERSON and HATCHETT, Circuit Judge, and NICHOLS*, Senior Circuit Judge.

Albert J. HENDERSON, Circuit Judge:

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*Honorable Phillip Nichols, Jr., U.S. Circuit Judge for the Federal Circuit, sitting by designation.

Joseph Alton Bowers sued the Continental Insurance Company (Continental) to recover certain optional person injury protection (PIP) benefits allegedly due him under two no-fault policies issued by Continental. The United States District Court for the Northern District of Georgia granted Continental's motion for summary judgment and motion to strike Bowers' request for attorney's fees, statutory penalties and punitive damages. We affirm.

Bowers is covered by two Continental no-fault insurance policies, each providing $5,000.00 in basic and $45,000.00 in optional PIP coverage. On August 24, 1981, while riding in a truck insured by the Aetna Insurance Company (Aetna), he

was involved in an accident as the result of which he incurred over $100,000.00 in medical expenses.

Aetna paid to Bowers $43,750.00 in PIP benefits.[1] During negotiations, Continental took the position that Bowers' total PIP recovery from Continental and Aetna could not exceed $50,000.00, the greatest amount of coverage available under any one of the policies.[2] Because Continental originally believed that Aetna paid the amount of $50,000.00, it claimed that

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[1] The benefits included $5,000.00 for basic PIP coverage and $38,750.00 for optional PIP coverage.

[2] See, e.g., Supp. Record, vol. 1, p. 12 (letter); Record at 266 (joint status report).

it was not indebted to Bowers for an additional amount.[3]

Bowers submitted copies of medical bills in excess of $92,000.00 along with a demand letter to Continental on April 26, 1982. On July 27, 1982, he filed a complaint in the State Court of DeKalb County, Georgia, against Continental seeking $42,419.10 in insur-

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[3] On April 26, 1982, Bowers' attorney sent a letter to Continental in which he stated that "my client has previously recovered personal injury protection benefits exhausting the $50,000 statutory amount of that policy from the insurance carrier insuring the motor vehicle which my client was operating at the time of the accident of August 24, 1981." Record at 29; see also Record at 171 (Continental's Response to Order of March 28, 1983) ("plaintiff received $50,000 in personal injury protection no fault benefits under the Aetna policy"). Bowers does not challenge Continental's original belief that Aetna paid him $50,000.00.

ance benefits and, because of the lateness of the payment allegedly due from Continental, a statutory penalty of $10,604.79, reasonable attorney's fees and punitive damages. Continental removed the case to the United States District Court for the Northern District of Georgia on the grounds of diversity. The district court later denied Bowers' motion to remand the case back to the state court.

On May 2, 1983, Continental learned that Aetna had paid only $43,750.00 in PIP benefits to Bowers.[4] Upon

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[4] The true amount of Aetna's payment was contained in Bowers' answers to Continental's interrogatories. These answers were mailed on April 29, 1983, and filed in the district court May 2, 1983. See Record at 189-93.

receipt of this information, Continental conceded that it owed Bowers the sum of $6,250.00, the difference between $50,000.00, the greatest amount of coverage available under any one of the policies, and Aetna's payment.[5] On May 31, 1983, Continental tendered a check for $6,250.00, but conditioned its acceptance on Bowers' release of all further claims against Continental.[6] Eventually, after Bowers refused to accept the payment, Continental forwarded another check for the same amount on

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5 See note 2, supra.

6 The tendered check contained a statement that the payment was for the "[r]elease of all claims on [Bowers' policy]." Supp. Record, vol. 1, p. 14. The check was accompanied by a release form and a draft order of dismissal. Id. at 15-16.

October 20, 1983, without the release provision.

The district court granted Continental's motion for summary judgment, and awarded Bowers $6,250.00, the amount Continental conceded it owed. In a later order the court granted Continental's motion to strike Bowers' request for attorney's fees, statutory penalties and punitive damages. This appeal followed.

Bowers first argues that the district court erred in denying his motion to remand the case back to the state court. According to Bowers, the suit was not removable because it falls under the direct action provision of 28 U.S.C. §1332(c):

> [I]n any direct action against the insurer of a policy or contract of liability insurance ... to which action the insured is not joined as a party-defendant, such insurer shall be deemed a citizen of the State of which the insured is a citizen, as well as of any State by which the insurer has been incorporated and of the State where it has its principal place of business.

28 U.S.C. 1332(c). Bowers argues that the district court lacked jurisdiction because, under the statute, his domicile must be imputed to Continental, thus destroying diversity.

At first glance, the literal language of the statute appears to support Bowers' contention. It is generally accepted that claims under no-fault insurance contracts may be considered "direct actions" within the meaning of

section 1332(c). See, e.g. Ford Motor Co. v. Insurance Co. of North America, 669 F.2d 421, 425-26 (6th Cir. 1982); McMurry v. Prudential Property and Casualty Insurance Co., 458 F. Supp. 209, 212-13 (E.D. Mich. 1978). Moreover, it is undisputed that this suit is "against the insurer of a policy ... of liability insurance," and that Bowers, the insured is "not joined as a party defendant."

Nonetheless, we do not believe that section 1332(c) applies to this action. The general rule has always been that the direct action proviso does not affect suits brought by an insured against his own insurer. See, e.g. White v. United States Fidelity and Guaranty Co., 356 F.2d 746, 747-48 (1st Cir. 1966). We are

aware of no authority to the contrary.[7] The proviso was passed in response to statutes authorizing actions against the holder of a contract of

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[7] Although constituting direct actions, the cases cited as contrary authority did not involve an insured suing his own insurer. For example, Ford Motor Co. v. Insurance Co. of North America, 669 F.2d 421 (6th Cir. 1982), was a suit against a resident tortfeasor's nonresident insurer. Although the Court held that Michigan's no-fault law acted as a "direct action" statute, the case was not one of an insured suing his own insurer. Similarly, in McMurry v. Prudential Property and Casualty Ins. Co., 458 F. Supp. 209 (E.D. Mich. 1978), an automobile passenger sued the owner-driver's no-fault insurer. In fact, the court explicitly stated that the proviso should apply, "at least ... where the named insured is not the plaintiff." Id. at 211. Finally, in Tyson v. Connecticut General Life Ins. Co., 495 F. Supp. 240 (E.D. Mich. 1980), the plaintiff sued the insurance company under contract to her employer to provide disability coverage.

indemnity for liability by a wrongdoer to the plaintiff. See S. Rep. No. 1308, 88th Cong., 2d Sess. reprinted in [1964] U.S. Code Cong. & Ad. News 2778, 2778-79; see also Spooner v. Paul Revere Life Insurance Co., 578 F. Supp. 369, 373 (E.D. Mich. 1984) (The direct action proviso is triggered by when "the act for which liability is sought to be imposed against the insurance company is the same act for which liability could be imposed against the insured."). In similar situations involving suits by an insured against his own insurer under an uninsured motorist policy, courts have held that section 1332(c) does not control. See, e.g. Adams v. State Farm Mutual Automobile Insurance Co., 313 F. Supp.

1349 (N.D. Miss. 1970); Bishop v. Allstate Insurance Co., 313 F. Supp. 875 (W.D. Ark. 1970). Accordingly, the district court did not err in denying Bowers' motion to remand.

Bowers next claims that he is entitled to recover PIP benefits in an amount greater than $50,000.00, the highest coverage on any one policy. In Voyager Casualty Insurance Co. v. King, 172 Ga. App. 269, 323 S.E.2d 4 (1984), cert. denied, No. 41655 (Ga., Nov. 6, 1984), the Georgia Court of Appeals resolved a previously unanswered question of state law by holding that optional PIP benefits could not be "stacked" to permit recovery in an amount greater than the highest coverage under any one policy.

As a result of this recent pronouncement by the state appellate court, Bowers is not entitled to additional benefits.[8]

Finally, Bowers asserts a claim for statutory penalties, attorney's fees and punitive damages. Georgia law provides that insurance benefits must be paid within thirty days after the insurer

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[8] Basic PIP coverage may not be "stacked" under Georgia law. See, e.g., Georgia Casualty & Surety Co. v. Waters, 146 Ga. App. 149, 246 S.E.2d 202 (1978). Here, Bowers contends that the optional PIP coverages may be "stacked." Under Voyager, however, he may recover optional benefits only up to the highest amount of optional PIP coverage afforded in any one policy, or $45,000.00. Since Aetna paid to Bowers only $38,750.00 in optional coverage, Continental admits it owes the remaining $6,250.00. The $5,000.00 difference between these figures and those used for convenience in the opinion is the basic PIP coverage paid to Bowers.

receives reasonable proof of the fact and amount of the loss obtained or the insurer shall be liable for a penalty not exceeding twenty-five percent of the amount due plus reasonable attorney's fees. In addition, if the delay exceeds sixty days the insurer is subject to punitive damages. In either case, the insurer may avoid liability by proving

that the failure to pay was in good faith. O.C.G.A. §33-34-6.[9]

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[9] Georgia law provides:

(b) Benefits required to be paid without regard to fault shall be payable monthly as loss accrues. The benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the fact and the amount of loss sustained.... In the event the insurer fails to pay each benefit when due, the person entitled to the benefits may bring an action to recover them and the insurer must show that its failure or refusal to pay was in good faith, otherwise the insurer shall be liable for a penalty not exceeding 25 percent of the amount due and reasonable attorney's fees.

(c) In addition to all other penalties provided for in this Code section, in the event an insurer fails or refuses to pay a person the benefits which the person is entitled to under this chapter within 60 days after proper proof of loss has been filed, the person may bring an action to recover the benefits; and, if the insurer fails to prove that its failure or refusal to pay the benefits was in good faith, the insurer shall be subject to punitive damages.
O.C.G.A. §33-34-6(b), (c).

Bowers contends that Continental is liable for these statutory penalties, attorney's fees and punitive damages because it failed to pay him the $6,250.00 it admitted it owed within the requisite time period.[10]

In interpreting this statute, a part of Georgia's no-fault automobile insurance act, Georgia courts have drawn on cases construing O.C.G.A. §33-4-6, a similar law applying generally to bad faith refusals to pay by insurers. See,

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[10] Bowers' claim for statutory damages attributable to Continental's refusal to pay an amount greater than $6,250.00 is without merit given the holding of the Georgia Court of Appeals in Voyager establishing that he is not entitled to this additional amount.

e.g., Bituminous Casualty Corp. v. Mowery, 145 Ga. App. 45, 244 S.E.2d 573 (1978). Georgia courts read this latter statute as requiring, as a condition to recovering bad faith damages, that the 30- or 60-day period lapse before the before the date suit is filed. See, e.g., Life Insurance Co. v. Burke, 219 Ga. 214, 222, 132 S.E.2d 737, 742 (1963); Cotton States Mutual Insurance Co. v. Clark, 114 Ga. App. 439, 446, 151 S.E.2d 780, 786 (1966). Because Bowers submitted his initial demand letter and adequate proof of loss on April 26, 1982, he may recover statutory damages only if Continental refused in bad faith to pay the $6,250.00 for thirty or sixty days after this date but before July 27, 1982, when he filed suit. A period of bad faith

withholding after suit is filed is insufficient under Georgia law.[11]

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[11] An insured may salvage a premature suit for statutory damages by dismissing it and refiling, see Piedmont Southern Life Ins. Co. v. Gunter, 108 Ga. App. 236, 132 S.E.2d 527 (1963) (dismissal did not prejudice the defendant's opportunity to pay the claim without liability for attorney's fees); Massachusetts Mutual Life Ins. Co. v. Montague, 63 Ga. App. 137, 10 S.E.2d 279 (1940) (amendment not permitted), or perhaps by filing an amendment in accordance with the liberalized Georgia Civil Practice Act. See generally Developments in Georgia Law-Insurance, 13 Ga. L. Rev. 850, 947 (1979). In this case, Bowers did neither.

We also note that there are some differences in the statutory language of O.C.G.A. §33-34-6, which is applicable here, and O.C.G.A. §33-4-6, from which we draw controlling precedent. For example, the former statute shifts the burden to the insurer to show good faith. None of these differences, however, lead us to conclude that Georgia courts would construe the former statute differently from the latter on the issues relevant to this case.

Continental has met its burden of showing good faith in withholding payment of the $6,250.00 between April 26, 1982, and July 27, 1982. It is undisputed that during this time Continental reasonably believed that Aetna had paid Bowers $50,000.00 rather than $43,750.00.[12] The district court did not err in granting Continental's motion to strike Bowers' request for statutory damages.

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12 See note 3, supra. Although the question of good or bad faith is generally for the jury, it may properly be decided by the court when there is no evidence of a frivolous or unfounded refusal to pay. See Georgia Farm Bureau Mutual Ins. Co. v. Pendley, 155 Ga. App. 674, 677-78, 272 S.E.2d 540, 543 (1980). Here, Bowers does not dispute the reasonableness of Continental's original belief that Aetna paid him the full $50,000.00.

AFFIRMED.

NICHOLS, Senior Circuit Judge, concurring:

I join in the opinion, but would add the following:

The Supreme Court has in recent years made quite a point of always giving federal statutes their literal interpretation as written, absent special factors such as reaching an absurd result, associated with pretty plain indications that Congress intended something different and of lesser scope. Such well known cases have so held as Tennessee Valley Authority v. Hill, 437 U.S. 153, 187 n. 33, 98 S. Ct. 2279, 2298 n. 33, 57 L. Ed.2d 117 (1978) (the snail darter case); Griffin v. Oceanic Contractors,

Inc., 458 U.S. 564, 102 S. Ct. 3245, 73 L. Ed.2d 973 (1982). The instant case made me uneasy because it was not made plain at first why "direct action" did not mean any and every "direct action" in which the insurer was duly named as a defendant. This court says this would appear to be the result "at first glance." The reported cases seem to pass over rather lightly why this is not so on second and subsequent glances. I think perhaps they took it for granted and were not yet warned by the Supreme Court not to rewrite or vary statutory language whenever it seemed good to them to do so.

The answer here is that from the beginning of §1332(c) "direct action" was

on the order of a term of art, not of one in common speech. It meant the right, given then by but two states, for motor vehicle tort plaintiffs to skip suing the tort feasor and sue directly his insurance carrier. Such appears in the legislative history. Senate Rep. No. 1308, 88th Cong., 2d Sess. (1964), reprinted in 1964 U.S. Code Cong. & Ad. News 2778. It calls such a statute a "direct action" statute, the words "direct action" in quotes at 2778. It refers to the two states as states which have "direct action" statutes. There is a detailed analysis of the spectacular effect of the Louisiana "direct action" statute upon the case load of the federal district courts in that state. The

The report ends with letters by Warren Olney and Deputy Attorney General Katzenbach, describing the bill as doing no more than eliminating from diversity jurisdiction suits on certain tort claims in which both parties are local residents but which, because of a state "direct action" statute, may be brought directly against a foreign insurance carrier.

This is the kind of thing I think the Supreme Court would accept as justifying a departure from its rule of strict and literal statutory construction.

To buttress further my belief that "direct action" and "direct action statutes" are, semantically, terms of art that refer not to any statute authorizing suit against an insurance company, but

only the special kind of which Louisiana and Wisconsin furnished the first examples, I refer to 12 Couch on Insurance 2d §45:775 & ff (1964) where such statutes are described and right away in §45:776 the writer starts calling them "direct action statutes." See also id, 1980 Supplement, §45:777 telling one that a direct action statute is not to be used to get an insurer into federal court when both the plaintiff and the insured are residents of the same state.

**APPENDIX "B"**

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

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Nos. 83-8787 and 84-8084

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JOSEPH ALTON BOWERS

Plaintiff-Appellant,

versus

CONTINENTAL INSURANCE COMPANY

Defendant-Appellee.

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Appeal from the United States District Court for the Northern District of Georgia

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ON PETITION FOR REHEARING AND SUGGESTION FOR REHEARING ENBANC

(Opinion February 27, 1985, 11 Cir., 1985, _____ F.2d _____).

Before HENDERSON and HATCHETT, Circuit Judges and Nichols,* Senior Circuit Judge.

PER CURIAM:

( X ) The Petition for Rehearing is DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 26), the Suggestion for Rehearing En Banc is DENIED.

( ) The Petition for Rehearing is DENIED and the Court having been polled at the request of one of the members of

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*Honorable Philip Nichols, Jr. U.S. Circuit Judge for the Federal Circuit sitting by designation.

the Court and a majority of the Circuit Judges who are in regular active service not having voted in favor of it (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 26), the Suggestion for Rehearing En Banc is also DENIED.

( ) A member of the Court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor of it, rehearing en banc is DENIED.

ENTERED FOR THE COURT:

/s/ Albert J. Henderson
United States Circuit Judge

## APPENDIX "C"

O.C.G.A. §33-34-4(a)(2) states:

> (2) Compensation to insured injured persons without regard to fault up to an aggregate minimum limit of $5,000.00 per insured injured person for:
>
> (A) All necessary medical expenses, not to exceed $2,500.00, arising from a motor vehicle accident, including necessary medicine, drugs, and surgical, dental, X-ray, and rehabilitative services, including prosthetic devices, and necessary ambulance, hospital, and nursing services as prescribed, authorized, approved, or rendered by an attending physician, including any person licensed to practice a healing art and any remedial treatment and care rendered in accordance with a recognized religious healing method;
>
> (B) Eighty-five percent of the loss of income or earnings during disability with a maximum benefit of $200.00 per week;

(C) Expenses, not to exceed $20.00 per day, reasonably incurred during a period of disability in obtaining ordinary and necessary services from others, excluding members of the injured person's household, in lieu of services that, had he or she not been injured, the injured person would have performed not for income but for the benefit of his or her household; and

(D) Funeral services and burial expenses not to exceed $1,500.00 per person.

O.C.G.A. §33-34-4(c) states:

The total benefits required to be paid under this Code section without regard to fault as the result of any one accident shall not exceed the sum of $5,000.00 per each individual covered as an insured person or such greater amount of coverage as has been purchased on an optional basis as provided in Code Section 33-34-5, regardless of the number of insurers providing such benefits or of the number

of policies providing such coverage.

O.C.G.A. §33-34-2(5) states:

> 'Insured' means, in addition to the insured named in the policy, his spouse and children if residing in the same household, the relatives of either the insured or his spouse if residents of the named insured's household, any pedestrian struck by the insured vehicle, and any other person using or occupying the insured vehicle with the express or implied permission of the named insured or his spouse. The term shall also include named insured, his spouse, and any resident relative while a pedestrian or while occupying or when struck by a motor vehicle when such motor vehicle is not similarly insured as required by paragraph (2) of subsection (a) of Code Section 33-34-4.

O.C.G.A. §33-34-5(a) states in pertinent part:

> Each insurer shall also make available on an optional basis the following coverage:

(1) An aggregate limit of benefits payable without regard to fault up to $50,000.00 per person, which may be rejected or reduced to not less than an aggregate limit of benefits payable without regard to fault of $5,000.00 per person by written consent of the policyholder. . . .

O.C.G.A. §33-34-6 provides as follows:

(a) Payment of benefits required by this chapter must be made periodically on a monthly basis as expenses are incurred or, in the case of total disability, as disability continues.

(b) Benefits required to be paid without regard to fault shall be payable monthly as loss accrues. The benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the fact and the amount of loss sustained. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof

is overdue if not paid within 30 days after proof is received by the insurer. Any part or all of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within 30 days after proof is received by the insurer. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address in a properly addressed, post-paid envelope or, if not so posted, on the date of delivery. Basic no-fault payments may be paid by the insurer directly to persons or firms supplying necessary products, services, or accomodations to the claimant. In the event the insurer fails to pay each benefit when due, person entitled to the benefits may bring an action to recover them and the insurer must show that its failure or refusal to pay was in good faith, otherwise the insurer shall be liable for a penalty not exceeding 25 percent of the

amount due and reasonable attorney's fees.

(c) In addition to all other penalties provided for in this Code section, in the event that an insurer fails or refuses to pay a person the benefits which the person is entitled to under this chapter within 60 days after proper proof of loss has been filed, the person may bring an action to recover the benefits; and, if the insurer fails to prove that its failure or refusal to pay the benefits was in good faith, the insurer shall be subject to punitive damages.

**CERTIFICATE OF SERVICE**

This is to certify that I have this date served three copies of the foregoing PETITION FOR WRIT OF CERTIORARI upon the United States Court of Appeals for the Eleventh Circuit, 50 Spring Street, S.W., Atlanta, Georgia 30303-3147, and upon William S. Sutton, attorney for Appellee, Continental Insurance Company, McClain & Merritt, P.C., 1250 Tower Place, Atlanta, Georgia 30026-3901 by depositing same in

the United States Mail in a properly addressed envelope with adequate postage thereon.

This 10 day of May, 1985.

By: _____
Ronald Arthur Lowry
Attorney for Petitioner,
Joseph Alton Bowers

Sworn to and subscribed before me this 10th day of May, 1985.

_____
Notary Public

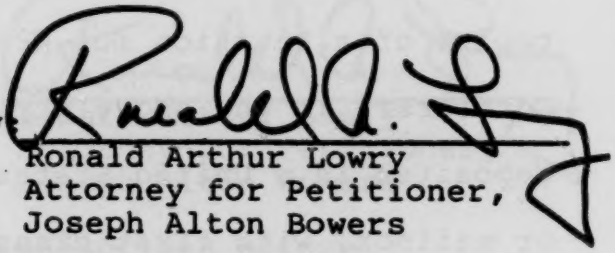
Notary Public, Georgia, State at Large
My Commission Expires June 3, 1986

**STATEMENT**

Pursuant to Rule 28.2 of the Rules of the Supreme Court, this statement certifies that the original and forty copies of a Petition for Writ of Certiorari in the above styled case were deposited in a United States post office or mailbox, with first class postage prepaid, and properly addressed to the Clerk of the Supreme Court of the United States. This mailing took place in Atlanta, Georgia on the afternoon of FRIDAY, May 10, 1985, within the time permitted by the Rules of the

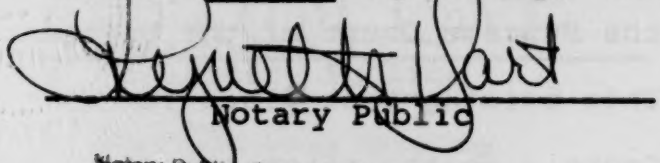
Supreme Court for the filing of a Petition for a Writ of Certiorari in this case.

Respectfully submitted,

By: 

Ronald Arthur Lowry
Attorney for Petitioner,
Joseph Alton Bowers

Sworn to and subscribed before me this 10th day of May, 1985.

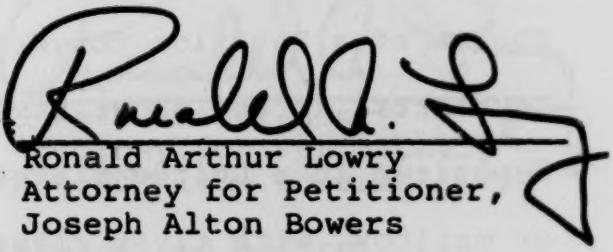


Notary Public

Notary Public, Georgia, State at Large
My Commission Expires June 3, 1986

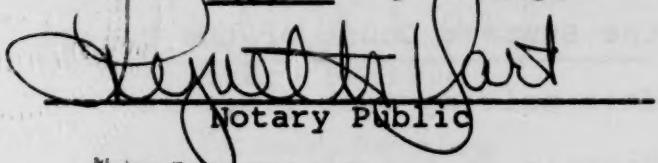
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Respectfully submitted,

By: 

Ronald Arthur Lowry
Attorney for Petitioner,
Joseph Alton Bowers

Sworn to and subscribed before me this 10th day of May, 1985.



Notary Public

Notary Public, Georgia, State at Large
My Commission Expires June 3, 1986